CMS Manual System

Pub. 100-09 Medicare Contractor Beneficiary and Provider Communications

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 9 **Date: MAY 6, 2005**

CHANGE REQUEST 3777

SUBJECT: Additions and Corrections to Provider Inquiry and Provider Communications Program Requirements

I. SUMMARY OF CHANGES: This updates IOM Pub 100-9, Chapters 3 and 4 with the instructions from the FY05 Provider Inquiries and Provider Communications BPRs, and makes minor language corrections or clarifications to existing requirements. New requirements deal with contractor provider telephone reporting specifications, procedures for handling provider inquiries, and information and features that must be on contractors' provider education websites. In addition, the Table of Contents for chapter 3 has been modified to reflect the section headings.

NEW/REVISED MATERIAL:
EFFECTIVE DATE: 02/01/2005 unless otherwise specified
IMPLEMENTATION DATE: June 6, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	3/Table of Contents
R	3/20.1/Guidelines for Telephone Service
R	3/20.1.1/Toll Free Network Services
R	3/20.1.2/ Publication of Toll Free Numbers
R	3/20.1.3/Call Handling Requirements
R	3/20.1.4/Customer Service Assessment and Management System (CSAMS) Reporting Requirements
R	3/20.1.7/Quality Call Monitoring (QCM)
R	3/20.1.10/Call Center User Group (CCUG)
R	3/20.1.11/Performance Improvements
D	3/20.1.12/Performance Improvements
R	3/20.2/Guidelines for Handling Written Inquiries
R	3/20.2.1/Contractor Guidelines for High Quality Written Responses to Inquiries

R	3/20.3 Walk-In Inquiries
R	4/20.1.7/New Technologies/Electronic Media
R	4/30.1.7/ New Technologies/Electronic Media

III. FUNDING: No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Attachment - Business Requirements

Pub. 100-09	Transmittal: 9	Date: May 5, 2005	Change Request 3777

SUBJECT: Update to Pub. 100-09, Medicare Contractor Beneficiary and Provider Communications, chapters 3 and 4.

I. GENERAL INFORMATION

A. Background: This CR updates IOM Pub 100-9, Medicare Contractor Beneficiary and Provider Communications, with the instructions in the FY05 Provider Inquiries and Provider Communications BPRs.

B. Policy: Sections 1816(a) and 1842(a)(3) of the Social Security Act require that Medicare contractors serve as a channel of communications for information to and from providers/suppliers. Medicare contractors are required by CMS to have Medicare provider (or supplier) communications and inquiries programs.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3777.1	Contractors shall notify CMS through the Service Reports mailbox at servicereports@cms.hhs.gov and their Regional Office prior to routing calls from one call center to another.	x	x	x	x					
3777.2	Contractors shall answer no less than 85 percent of all callers who choose to speak with a CSR within the first 60 seconds of their delivery to the queuing system. This standard will be measured quarterly and will be cumulative for the quarter.	x	x	x	x					
3777.3	Contractors shall handle no less than 90 percent of the calls to completion during the initial contact with a CSR. This standard will be measured quarterly and will be cumulative for	x	x	x	x					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	the quarter.									
3777.4	Contractors shall have a completion rate of no less than 80 percent for CSR and IVR combined lines. This standard will be measured quarterly and will be cumulative for the quarter.	x	x	x	x					
3777.5	Contractors shall have a completion rate of no less than 80 percent for CSR – only lines. This standard will be measured quarterly and will be cumulative for the quarter.	x	x	x	x					
3777.6	Contractors shall have a completion rate of no less than 95 percent for IVR – only lines. This standard will be measured quarterly and will be cumulative for the quarter.	x	x	x	x					
3777.7	Contractors shall include on their IVR the definitions for the 100 most frequently used remittance advice codes. Contractors are not limited to 100 definitions and may add more if their system has the capability to handle the information. If this capability does not presently exist, then the contractor shall develop a detailed cost breakdown, including necessary hardware and software, for installing the capability as described above. The developed cost estimate shall be submitted with the contractor's FY 2005 budget request. CMS will assume those centers that do not submit a detailed cost estimate for this item currently meet the requirement and do not need additional funding.	x	x	x	x					
3777.8	For claims status inquiries handled by the IVR, contractors shall adhere to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule by authenticating the caller by using at least the following information: • Provider Number	x	x	x	x					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	• HIC Number • Date of Service									
3777.9	For all calls monitored for the quarter, the contractors shall have no less than 93 percent of the number of CSRs scoring as "Pass" for Adherence to Privacy Act. During the quarter no month shall fall below 85 percent. This standard will be measured quarterly and will be cumulative for the quarter.	x	x	X	x					
3777.10	For all calls monitored for the quarter, the contractors shall have no less than 93 percent of the number of CSRs scoring as "Achieves Expectations" for Customer Skills Assessment. During the quarter no month shall fall below 85 percent. This standard will be measured quarterly and will be cumulative for the quarter	x	x	x	x					
3777.11	For all calls monitored for the quarter, the contractors shall have no less than 93 percent of the number of CSRs scoring as "Achieves Expectations" for Knowledge Skills Assessment. During the quarter no month shall fall below 85 percent. This standard will be measured quarterly and will be cumulative for the quarter.	x	x	x	x					
3777.12	Contractors shall respond to at least three issues during one provider/supplier phone call.	x	x	x	x					
3777.13	Contractors shall provide for the deaf, hard of hearing or speech impaired, the ability to communicate via Teletypewriter (TTY) equipment. Contractors shall provide this service as of December 1, 2004. If this capability does not presently exist, then the contractor shall develop a detailed cost breakdown, including necessary hardware and	x	x	x	x					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	software, for installing the capability as described above. The developed cost estimate shall be submitted with the contractor's FY 2005 budget request. CMS will assume those centers that do not submit a detailed cost estimate for this item currently meet the requirement and do not need additional funding.									
3777.14	Contractors shall capture and report to CSAMS monthly the "Number of Attempts" to their TTY/TDD line.	x	x	x	x					
3777.15	Contractors shall capture and report to CSAMS monthly the "Number of Failed Attempts" to their TTY/TDD line.	x	x	x	x					
3777.16	Contractors shall capture and report to CSAMS monthly the "Number of Attempts" to their IVR only line.	x	x	x	x					
3777.17	Contractors shall capture and report to CSAMS monthly the "Number of Failed Attempts" to their IVR only line.	x	x	x	x					
3777.18	The contractor shall provide CMS with the capability to remotely monitor provider calls. The following requirements clarify how the remote monitoring system shall be set up. CMS monitoring personnel shall have the capability to monitor provider calls by: • Specific workstation (CSR); • Next call from the network or next call from the CSR queue; or • Specific business line (Carrier, Fiscal Intermediary, or DMERC). If this capability does not presently exist, then the contractor shall develop a detailed cost breakdown, including necessary hardware and software, for installing the capability as	x	x	x	x					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	described above. The developed cost estimate shall be submitted with the contractor's FY 2005 budget. Contractors shall not take any steps to procure or install new remote monitoring equipment without prior approval from CMS. CMS will assume those centers that do not submit a detailed cost estimate for this item currently meet the requirement and do not need additional funding to comply.									
3777.19	Contractors shall date stamp the cover page of all written inquiries and the top page of all attachments.	x	x	x	x					
3777.20	Contractors shall use the name provided by the incoming correspondence or name in the system as the salutation for written inquiries. "Dear Provider" is not to be used.	x	x	x	x					
3777.21	Contractors shall send a final response to all provider inquiries within 45 business days.	x	x	x	x					
3777.22	Contractors' provider website homepage shall include a tutorial explanation of how to use the website. The tutorial must describe how to navigate through the site, how to find information, and explain features of the site. This shall be operational 30 days after issuance.	x	x	x	x					
3777.23	Contractors shall include on their provider education website a "Site Map" that shows in simple text headings the major components of your provider/supplier website and allows users direct access to these components through selecting and clicking on titles. This feature must be accessible from the home page of the website using the words "Site Map" and must be operational by May 1, 2005.	x	x	x	x					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3777.24	Contractors' provider education websites shall include a mechanism for providers to offer feedback regarding contractors' performance. This information shall be located within the feedback mechanism for users of the website. Contractors shall use the post office mailing address of the CMS Regional Office PCOM coordinator as the referral point for the feedback. This information shall be on contractors' websites by May 1, 2005.	x	x	x	x					
3777.25	Contractors shall actively promote the benefits of being a member of their listserv(s) to their provider community in order to encourage them to join. The total of unique, individual active members of a contractor's listserv(s) must be at 60 % or higher of their active provider population by September 30, 2005.	x	x							
3777.26	Contractors shall actively promote the benefits of being a member of their listserv(s) to their provider/supplier community in order to encourage them to join. The total of unique, individual active members of a contractor's listserv(s) must be at 25 % or higher of their active provider population by September 30, 2005.			x	x					

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: February 1, 2005 unless otherwise specified in the instructions. **Implementation Date: June 6, 2005** **Pre-Implementation Contact(s):** Emily Norment, 410-786-0495 (Provider Inquiries); Harvey Tzucker, 410-786-3670 (Provider Communication)	**No additional funding will be provide by CMS; contractor activities are to be carried out within their FY 2005 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

Medicare Contractor Beneficiary and Provider Communications Manual

Chapter 3 - Provider Customer Services

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(Rev.9, 05-06-05)

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20.1 - Guidelines for Telephone Service

(Rev. 9, Issued: 05-06-05, Effective: 02-01-05, Implementation: 06-06-05)

The guidelines established below apply to contractors' general provider inquiry telephone numbers. The standards shall not apply to those inquiries handled by other units within the contractor (e.g., appeals, fraud, MSP). To ensure all inquiries are handled as expeditiously as possible, inbound provider inquiry numbers (and the lines) shall be separate from beneficiary inquiry numbers. Providers shall not use numbers established for beneficiary inquiries.

A - Availability of Telephone Service

1. Contractors shall make CSR telephone service available to callers continuously during normal business hours, including lunch and breaks. Normal business hours for live telephone service are defined as 8:00 a.m. through 4:30 p.m. for all time zones of the geographical area serviced, Monday through Friday. Where contractors provide national coverage or where contractors serve areas outside of the continental United States, CMS will entertain a waiver request for hours of operation.

2. On Federal holidays, in lieu of answering telephone inquiries, contractors may choose to perform other appropriate call center work, e.g., provide CSR training. Contractors shall notify CMS via the service reports mailbox (servicereports@cms.hhs.gov) by October 31st of the fiscal year about any planned call center closures. This list shall also be sent to the appropriate RO. Changes may be made to this schedule during the fiscal year and shall be sent to CMS CO and RO prior to the holiday impacted by the change. Call centers shall notify the provider community of the planned closure.

3. Call center staffing shall be based on the pattern of incoming calls per hour and day of the week, ensuring that adequate coverage of incoming calls throughout each workday is maintained.

4. *In accordance with Section 508 of the Rehabilitation Act of 1973 and the Workforce Investment Act of 1998, all call centers shall provide the ability for deaf, hard of hearing or speech-impaired providers to communicate via TeleTYpewriter (TTY) equipment. A TTY is a special device permitting, hard of hearing, or speech-impaired individuals to use the telephone, by allowing them to type messages back and forth to one another instead of talking and listening. (A TTY is required at both ends of the conversation in order to communicate.) Call centers currently having the ability to provide this service for beneficiary callers may use the same equipment, however, they may not use the same inbound lines. Contractors shall follow the process outlined in IOM, Pub. 100-9, Chapter 3, §20.1.1.B to request additional lines to handle this requirement. Contractors shall publicize the TTY line on their websites.*

B - Automated Services-Interactive Voice Response (IVR)\

1. Although the provider shall have the ability to speak to a CSR during normal call center operating hours, automated "self-help" tools, such as IVRs, shall also be used by all contractors to assist with handling inquiries. IVR service is intended to assist providers in obtaining answers to various Medicare questions, including those listed below:

- Contractor hours of operation for CSR service

- General Medicare program information. (Contractors shall target message duration to be under 30 seconds. Contractor shall have the technical capability to either require callers to listen or to allow them to bypass the message as determined by CMS. In cases where CMS makes no determination the contractor shall use their own discretion.)

- General information about appeal rights and actions required of a provider to exercise these rights

- Specific information about claims in process and claims completed. (By October 31st of the fiscal year, those call centers providing claim specific information through the IVR shall indicate how they are authenticating the caller. A copy shall be sent to both the contractor's RO contact and to the service reports mailbox at servicereports@cms.hhs.gov.). *For claims status inquiries handled in the IVR, all call centers shall adhere to the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule by authenticating the caller by using at least the provider number, HIC number, and date of service.*

- *Definitions for the 100 most frequently used Remittance Codes as determined by each contractor. Contractors are not limited to 100 definitions and may add more if their system has the capability to handle the information. This requirement may be satisfied by providing Remittance Code definitions for specific provider IVR claim status inquiries.*

NOTE: IVRs shall be updated to address areas of provider confusion as determined by contractors' inquiry analysis staff and CMS best practices at least once every six months.

2. Call centers shall submit to CMS a call flow document that outlines their IVR scripts and call flow, clearly showing all provider inquiry transactions that they are performing through their IVR. Contractors shall also indicate how they are authenticating the call when claims specific information is involved. The contractors can deliver this document in Visio, Paintbrush, Word, or PowerPoint. A copy shall

be sent to both the contractor's RO and to the central office (CO) at servicereports@cms.hhs.gov. If the contractor changes the IVR script or call flow, they shall submit the revised document to these parties within 2 weeks of implementing the changes.

3. The IVR shall be available to providers 24 hours a day with allowances for normal claims processing and system mainframe availability, as well as normal IVR and system maintenance. When information is not available, contractors shall put a message alerting providers. Waivers shall be granted as needed to allow for normal IVR and system maintenance.

NOTE: IVRs shall be programmed to provide callers with an after-hours message indicating normal business hours. (It is not necessary to duplicate this message if the caller is informed of the normal business hours via the telephone system prior to being delivered to the IVR.)

4. Contractors shall print and distribute a clear IVR operating guide to providers upon request. The guide shall also be posted on the contractor's Web site.

5. Contractors who are able to provide claims status information through their IVR shall require providers to use the IVR to obtain this information.

6. The CMS will evaluate the quality of the contractors' IVRs. These evaluations will be based on the following:

    - IVR Availability
    - Accuracy of the information provided
    - Timeliness of the information provided
    - Quality of the information provided
    - Tone

C– Provider Satisfaction Survey

Contractors shall have the ability to incorporate a short CMS-created provider satisfaction survey in their Interactive Voice Response Unit (IVR) to be accessed by a transfer from the Customer Service Representative (CSR). The survey will use touch-tones; therefore speech recognition is not required to meet this requirement.

20.1.1 - *Toll Free Network Services*

(Rev. 9, Issued: 05-06-05, Effective: 02-01-05, Implementation: 06-06-05)

A - Inbound Services

The CMS will use the General Services Administration's FTS 2001 contract for its toll-free network. All inbound provider telephone service will be handled over the toll-free FTS network, with the designated long-distance contractor. Any new toll-free numbers

and the associated network circuits used to carry these calls shall be acquired via the FTS 2001 network. Contractors shall not maintain their own local inbound lines.

B - Processes for Ordering More Lines, Changing Configurations, or Disconnecting Lines

1. The ongoing management of the entire provider toll free system requires a process for making changes, which may be initiated by either contractor or CMS. All change requests associated with the FTS 2001 network (e.g., adding or removing channels or TIs, office moves, routing changes), shall be processed through the Provider Telecommunications Technical Support Contractor (TSC). Contact information for the TSC is located at http://www.cms.hhs.gov/contractors/customerserv/network.asp. Any CMS-initiated changes (i.e., adding lines, removing lines, reconfiguring trunk groups) will be based upon an analysis of CSAMS data and traffic reports.

2. If a contractor is requesting changes they shall provide an analysis of their current telephone environment (including a detailed traffic report) specific to the service being requested that shows the need for changes to their phone system (i.e., additional lines, trunk group reconfiguration). This information shall be gathered at the contractor site through the contractor's switch and through the MCI Customer Center reports. This information should be sent to CO and the appropriate RO. Based on technical merit and availability of funds, CO will review the recommendation and make a determination. In cases where the request is approved, CO will forward approved requests to the designated agency representative (DAR) for order issuance.

C – Troubleshooting

To ensure that provider toll-free service is available and clear, CMS established the Provider Incident Reporting & Response System (PIRRS). The PIRRS establishes a standard incident response and resolution system for Medicare contractors who are troubleshooting problems. The CMS has assembled a multi-functional team, consisting of both MCI telecommunications support and personnel from the TSC to quickly and effectively resolve reported problems.
To report and monitor a problem, contractors shall follow these steps:

Step 1

Isolate the problem and determine whether it is caused by internal customer premise equipment or the toll-free network service.

- Internal Problem - The contractor's local telecommunications personnel shall resolve, but report per steps below.

- Toll-Free Network Service Problem - Contractor reports the problem to MCI by calling 1-888-387-7821.

Step 2

Involve personnel from the provider TSC, if needed, to answer technical questions or to facilitate discussions with the MCI Help Desk. Contact information for the TSC is located at http://www.cms.hhs.gov/contractors/customerserv/network.asp

Step 3

File an incident report with the provider TSC for major interruptions of service. The TSC will notify the appropriate CMS staff. Major interruption of service is defined as any incident with a trouble ticket opened for more than 24 hours or a total loss of service. The contractor shall send an email to service reports that summarizes the problem and the steps taken to restore full service. The contractor shall send a follow-up email to service reports when the problem has been resolved.

Step 4

Use MCI's Customer Service Center to review documentation, track trouble tickets, or to close a trouble ticket online.

Step 5

File a monthly report with CMS at servicereports@cms.hhs.gov about interruption of service - including both MCI related and in-house and send a copy to the contractor's RO.

D - Disaster Recovery

1. When a call center is faced with a situation that results in a major disruption of service, the call center shall take the necessary action to ensure that callers are made aware of the situation. This service is intended to supplement the contractor's existing disaster recovery or contingency plans. Whenever possible, the call center is responsible for activating its own emergency messages or re-routing calls. However, when this is not possible and providers are unable to reach the call center switch, the call center shall contact the Beneficiary Network Services Center (BNS) and request that they initiate a pre-scripted disaster recovery message based in the FTS 2001 network. Contact information for the BNS is located at http://www.cms.hhs.gov/contractors/customerserv/network.asp. Once the problem is resolved, the call center shall also contact the BNS to de-activate the FTS 2001 network disaster messages. For provider only call centers, contractors shall contact the BNS only for the disaster situations. It will manage only these types of requests. The CMS designated the single point of contact to streamline the process for shared call centers and avoid making two calls in an emergency situation. The BNS contacts and updates the provider TSC when a provider call center disaster situation occurs. For all other FTS 2001 support requests, provider call centers shall follow their normal procedures.

By December 31st of each fiscal year, call centers shall update their written contingency plan describing how the Medicare provider telecommunications operations will be maintained or continued in the event of manmade or natural disasters. The plan shall cover partial loss of telecommunications capabilities due to equipment or network failures through the total loss of a call center. The plan may include arrangements with one or more other contractors to assist in telephone workload management during the time the call center is unable to receive provider phone calls. Plans may be submitted to the service reports mailbox at servicereports@cms.hhs.gov or via postal mail, with a copy to the RO. Contractors may choose to submit the portion of their contingency plan developed under Activity Code 11206 that deals with their call center. In the event that the contractor develops a different plan related only to their call center, these costs shall be charged to 33001, not 11206.

E - Inbound Service Costs

The CMS will pay for the rental of inbound T-1/PRI lines and all connect time charges for FTS-2001 toll-free service. The costs associated with the installation and monthly fees for this toll-free service will be paid centrally by CMS and shall not be considered by contractors in their budget requests. However, contractors shall still be responsible for all other internal telecommunications costs and devices such as agent consoles, handsets, internal wiring and equipment (ACD, IVR, PBX, etc.) and any local or outbound telephone services and line charges. Since these costs are not specifically identified in any cost reports, contractors shall maintain records for all costs associated with providing telephone service to providers (e.g., costs for headsets) and shall provide this information upon request by RO or CO.

20.1.2 - *Publication of Toll Free Numbers*

(Rev. 9, Issued: 05-06-05, Effective: 02-01-05, Implementation: 06-06-05)

A - Directory Listings

Contractors shall not be responsible for the publication of their inbound 800 services in any telephone directory. However, at their discretion, contractors may choose to publish their general provider toll free number in the directory they feel is most appropriate.

B - Printing Toll Free Numbers on Provider Notices

Any toll-free Medicare provider customer service number provided and paid for by CMS shall be printed on all provider notices, (RAs, etc.) immediately upon activation. Contractors shall display this toll-free number prominently so the reader will know whom to contact regarding the notice.

C – Publicizing Toll Free Numbers on the Web

Any toll-free Medicare provider customer service number provided and paid for by CMS shall be prominently displayed on the contractor's Web site.

20.1.3 - Call Handling Requirements

(Rev. 9, Issued: 05-06-05, Effective: 02-01-05, Implementation: 06-06-05)

A - Call Acknowledgement

Contractors shall program all systems related to inbound provider calls to the center to acknowledge each call within 20 seconds before a CSR, IVR or ACD prompt is reached. This measure shall be substantiated and/or reported upon request by CMS.

B - Providing Busy Signals

Call center customer premise equipment shall not be configured/programmed to return, "soft busies." Contractor call centers shall only provide "hard" busy signals to the FTS network. At no time, shall any software, gate, vector, application, IVR, and/or ACD/PBX accept the call by providing answer back supervision to the FTS network and then providing a busy signal to the caller and/or dropping the call. The contractor shall optimize their inbound toll-free circuits to ensure the proper ratio of circuits to existing FTEs.

C – *Call Routing*

When a call center routes calls to another site, CMS needs to make sure that the contractor handling the calls gets credit for the work. If a call is forwarded over a contractor's system there is no way for CMS to determine the final termination point of the call. Therefore, prior to transferring calls to another center, contractors shall notify CMS through the Service Reports mailbox at servicereports@cms.hhs.gov. Contractors shall also notify the appropriate Regional Office.

D - Queue Message

Contractors shall provide a recorded message that informs callers waiting in queue to speak with a CSR of any temporary delay before a CSR is available. They shall use the message to inform the provider to have certain information readily available (e.g., health insurance claim number) before speaking with the CSR. The queue message shall also be used to indicate non-peak time frames for callers to call back when the call center is less busy.

E – General Inquiries Line

The provider toll free numbers installed for Part A, Part B, DMERC, and RHHI general provider inquiry traffic shall not be used for other applications (e.g., MSP, reviews, EDI, provider enrollment, and other non-claim related provider inquiries) beyond answering general questions for each application. At a minimum, these general lines shall be used

to handle questions related to billing, claims, eligibility, and payment. Complex questions (ones that might currently require an internal transfer) shall be directed to the "other" units on a different toll free number than the general inquiry number. It is not necessary for each "other" function to have its own unique toll free number, although contractors can choose this option. Other acceptable options are having a single "other" toll free number to handle all the "other" (non general inquiry) functions or a few "other" toll free numbers handling more than one "other" function via each number. The CSRs on the general inquiry line shall not transfer callers to the "other" functional units but rather shall instruct the caller to hang up and dial the appropriate number. "Other" numbers shall not be subject to CSAMS reporting or the call performance standards that govern the general inquiries line. If contractors need toll free service for other Medicare applications currently being handled on the provider claims inquiry toll free numbers, please follow the established process for adding additional toll free numbers. We will consider all requests for additional toll free numbers.

F - CSR Identification to Callers

The CSRs shall identify themselves when answering a call, however the use of both first and last names in the greeting is optional. In order to provide a unique identity for each CSR for accountability purposes, where a number of CSRs have the same first name, it is suggested that the CSRs also use the initial of their surname. If the caller specifically requests that a CSR identify himself/herself, the CSR shall provide both first and last name. Where the personal safety of the CSR is an issue, call center management shall permit the CSR to use an alias. This alias shall be known for remote monitoring purposes. The CSRs shall also follow local procedures for escalating calls to supervisors or managers in situations where warranted.

G- Sign-in Policy

Contractors shall establish and follow a standard CSR sign-in policy in order for CMS to ensure that data collected for telephone performance measurement are consistent from contractor to contractor. The sign-in policy shall include the following:

- The CSRs available to answer telephone inquiries shall sign-in to the telephone system to begin data collection;

- The CSRs shall sign-off the telephone system for breaks, lunch, training, and when performing any other non-telephone inquiry workload. (Note: If the telephone system supports an additional CSR work-state or category that accumulates this non-telephone inquiry performance data so that it can be separated and not have any impact on the measurements CMS wants to collect, this work-state or category may be utilized in lieu of CSRs signing-off the system; and

- The CSRs shall sign-off the telephone system at the end of their workday.

H - Service Level

Contractors shall answer no less than 85 percent of all callers who choose to speak with a CSR within the first 60 seconds of their delivery to the queuing system. *This standard will be measured quarterly and will cumulative for the quarter.*

I - Initial Call Resolution

Contractors shall handle no less than 90 percent of the calls to completion during the initial contact with a CSR. A call is considered resolved during the initial contact if it does not require a return call by a CSR. *This standard will be measured quarterly and will cumulative for the quarter.*

J – Call Completion

- Each *CSR and IVR combined* line shall have a completion rate of no less than 80%. *This standard will be measured quarterly and will cumulative for the quarter.*

- Each *CSR-only* line shall have a completion rate of no less than 80%. *This standard will be measured quarterly and will cumulative for the quarter.*

- *Each IVR-only line shall have a completion rate of no less than 95%. This standard will be measured quarterly and will be cumulative for the quarter.*

K - Quality Call Monitoring:

- Frequency of Monitoring: Contractors shall monitor a minimum of three calls per CSR per month. In centers where CSRs answer both beneficiary and provider calls, monitor a minimum of three calls, including at least one of each type, during the month. Any deviation from this requirement shall be requested and justified to the RO in order to determine if a waiver is warranted.

- Performance Standards for Quality:

    - Of all calls monitored *for the quarter*, the number of CSRs scoring as "Pass" for Adherence to Privacy Act shall be no less than *93* percent. *During the quarter, no month shall fall below 85 percent. This standard will be measured quarterly and will be cumulative for the quarter.*

    - Of all calls monitored *for the quarter*, the percent of CSRs scoring as "Achieves Expectation" or higher shall be no less than *93* percent for Customer Skills Assessment. *During the quarter, no month shall fall below 85 percent. This standard will be measured quarterly and will be cumulative for the quarter.*

- Of all calls monitored *for the quarter*, the percent of CSRs scoring as "Achieves Expectation" or higher shall be no less than *93* percent for Knowledge Skills Assessment. *During the quarter, no month shall fall below 85 percent. This standard will be measured quarterly and will be cumulative for the quarter.*

L - Equipment Requirements:

- To ensure that inquiries receive accurate and timely handling, contractors shall provide the following equipment:

  1. Online access to a computer terminal for each CSR responsible for claims-related inquiries. Locate the computer terminal so that representatives can research data without leaving their seats.

  2. Access to the contractor's Web site and www.cms.hhs.gov.

  3. An outgoing line for callbacks.

  4. A supervisory console for monitoring CSRs.

- Any contractor call center purchases or developmental costs for hardware, software or other telecommunications technology that equal or exceed $10,000 shall first be approved by CMS. Contractors shall submit all such requests to the servicing RO for review. The RO shall forward all recommendations for approval to CO for a final decision.

M – Limiting the Number of Issues Per Call
Call centers may limit the number of issues discussed during one phone call, but all call centers shall respond to at least three issues before asking the provider to call back.

20.1.4 - Customer Service Assessment and Management System (CSAMS) Reporting Requirements

(Rev. 9, Issued: 05-06-05, Effective: 02-01-05, Implementation: 06-06-05)

The CSAMS is an interactive Web-based software tool used by CMS to collect and display call center telephone performance data. Each call center site shall enter required telephone customer service data elements into CSAMS between the 1st and 10th of each month for the prior month. To change data after the 10th of the month, users shall inform CO via CSAMS at csams@cms.hhs.gov. In those rare situations where one or more data elements are not available by the 10th of the month, the missing data shall not prevent the call center from entering all other available data into CSAMS timely. The call center shall supply the missing data to CMS within two workdays after it becomes available to the contractor. Definitions, calculations and additional information for each of the required telephone customer service data elements as well as associated standards are posted on the CMS' telephone customer service Web site at

https://bizapps.cms.hhs.gov/csams. Call centers shall use CSAMS call handling data to improve call center performance.

A - Definition of Call Center for CSAMS

All contractors shall ensure that monthly CSAMS data are being reported by individual call centers and that the data are not being consolidated. The CMS wants telephone performance data reported at the lowest possible physical location in order to address performance concerns. A call center is defined as a location where a group of CSRs are answering similar type calls (A, B, DMERC, A&B, or some breakout or consolidation of these calls). The physical location could be in the same room, building, or complex but not in a separate geographic location, city, state, etc.

B - Data to Be Reported Monthly

Contractors shall capture and report the following data each month:

- Number of Attempts - This is the total number of calls offered to the provider call center via the FTS Toll-Free during the month. This shall be taken from reports produced by FTS toll-free service provider. The current provider is MCI and the reports are available at their Web site https://www.mcicustomercenter.com/

- Number of Failed Attempts - This represents the number of calls unable to access the call center via the toll-free line. This data shall be taken from reports produced by FTS toll-free service provider. The current provider is MCI and the reports are available at their Web site https://www.mcicustomercenter.com/

- *Number of Attempts (TTY/TDD) - This is the total number of calls offered to the TTY/TDD line at the provider call center via the FTS Toll-Free during the month. This shall be taken from reports produced by FTS toll-free service provider. The current provider is MCI and the reports are available at their Web site https://www.mcicustomercenter.com/*

- *Number of Failed Attempts (TTY/TDD) - This represents the number of calls unable to access the call center via the TTY/TDD toll-free line. This data shall be taken from reports produced by FTS toll-free service provider. The current provider is MCI and the reports are available at their Web site https://www.mcicustomercenter.com/*

- *Number of Attempts (for those call centers with IVR-only lines) - This is the total number of calls offered to the IVR-only line at the provider call center via the FTS Toll-Free during the month. This shall be taken from reports produced by FTS toll-free service provider. The current provider is MCI and the reports are available at their Web site https://www.mcicustomercenter.com/*

- *Number of Failed Attempts for those call centers with IVR-only lines) - This represents the number of calls unable to access the call center via the IVR-only toll-free line. This data shall be taken from reports produced by FTS toll-free service provider. The current provider is MCI and the reports are available at their Web site https://www.mcicustomercenter.com/*

- Call Abandonment Rate - This is the percentage of provider calls that abandon from the ACD queue. This shall be reported as calls abandoned up to and including 60 seconds.

- Average Speed of Answer - This is the amount of time that all calls waited in queue before being connected to a CSR. It includes ringing, delay recorder(s), and music. This time begins when the caller enters the CSR queue and includes both calls delayed and those answered immediately.

- Total Sign-in Time (TSIT) - This is the amount of time the CSRs were available to answer telephone inquiries. This time includes the time that CSRs were plugged-in, logged-in, handling calls, making outgoing calls, in the after call work state or in an available state.

- Number of Workdays - This is the number of calendar days for the month that the call center is open and answering telephone inquiries. For reporting purposes, a call center is considered open for the entire day even if the call center was closed for a portion of the day and/or not able to answer telephone inquiries for a portion of the day.

- Total Talk Time - This is the total amount of time that all CSRs were connected to callers and includes any time the caller is placed on hold by the CSR during the conversation.

- Available time - Available time is the amount of time that CSRs were signed-in on the telephone system waiting for a call to be delivered (i.e., the CSR is not handling calls, making outgoing calls, or in the after call work (ACW) state).

- After Call Work Time - This includes the time that CSRs need to complete any administrative work associated with a call after the customer disconnects.

- Status of Calls Not Resolved at First Contact - Report as follows:

    1. Number of callbacks required. This number is based on calls received for the calendar month and represents the number requiring a callback as of the last workday of the month.

    2. Number of callbacks closed within 5 workdays. This number is based on calls received for the calendar month and represents the number closed within 5 workdays even if a callback is closed within the first 5 workdays of the

following month. For call centers that have transitioned to the Next Generation Desktop, the collection of this data point will be automated and will be based on 7 calendar days rather than 5 workdays.

- IVR Handle Rate - Report data needed to calculate the IVR handle rate.
  For call centers with combined CSR and IVR lines this includes:

  1. The number of calls offered to the IVR (defined as the total number of calls receiving a prompt offering the use of the IVR during or after business hours); and

  2. The number of calls handled by the IVR (defined as the number of calls where the caller selected and played at least one informational message and did not subsequently transfer to a CSR).

  For call centers with separate CSR and IVR lines this includes:

  1. The number of calls offered to the IVR (defined as the total number of *IVR-only* calls receiving a prompt offering the use of the IVR during or after business hours *plus the total number of CSR completed calls*); and

  2. The number of calls handled by the IVR (defined as the number of calls where the caller selected and played at least one informational message).

- Calls in CSR queue - This is the total number of calls delivered to the CSR queue.

- Calls Answered by CSRs - This represents the total number of calls answered by all CSRs for the month from the CSR queue.
- Calls Answered <= 60 Seconds - This represents the total number of calls answered by all CSRs within 60 seconds from the CSR queue.

- Quality Call Monitoring (QCM)-Number of CSRs Available for Monitoring - This is the number of CSRs (not FTEs) that take calls on a regular basis, both full-time and part-time CSRs. This number is obtained from the QCM Database.

- QCM-Number of Completed Scorecards – This is the number of scorecards that were completed and entered into the QCM database for the month. This number is obtained from the QCM Database.

- QCM-Customer Skills Assessment - This is the percent of calls monitored that scored greater than or equal to Achieves Expectations. This number is obtained from the QCM Database.

- QCM-Knowledge Skills Assessment - This is the percent of calls monitored that scored greater than or equal to Achieves Expectations. This number is obtained from the QCM Database.

- QCM-Privacy Act - This is the percentage of calls that scored as pass. This number is obtained from the QCM Database.

20.1.7 - Quality Call Monitoring (QCM)

(Rev. 9, Issued: 05-06-05, Effective: 02-01-05, Implementation: 06-06-05)

Contractors shall:

A - Process and Tools

1. Monitor, measure and report the quality of service continuously by utilizing the CMS-developed QCM process. Contractors shall monitor all CSRs throughout the quarter, using a sampling routine. The sampling routine shall ensure that all CSRs are monitored at the beginning, middle and end of each month (ensuring that assessments are distributed throughout the week), and during morning and afternoon hours. If there is more than one auditor, contractors shall rotate the CSR monitoring assignments regularly among the auditors.

2. Record all monitored calls on the standard scorecard, using the QCM chart as a guideline. Copies of the scorecard and chart can be obtained at QCM database Web site at https://www.qcmscores.com. Contractors shall use only the official versions of the scorecard and chart that are posted on the Web site. The QCM database, also available on the Web site, shall be used to collect monitoring results that will be reported monthly in CSAMS.

3. Train every CSR and auditor on the scorecard, chart and database and ensure that each person has a copy of the chart for reference. Contractors shall analyze individual CSR data frequently to identify areas needing improvement, document and implement corrective action plans.

4. Analyze QCM data to develop a plan for continuous improvement and to determine where training is indicated, whether at the individual, team, or call center level and provide such training.

B - Frequency of Monitoring

- Experienced CSRs - Monitor a minimum of 3 calls per CSR per month. In centers where CSRs answer both beneficiary and provider calls, monitor a minimum of 3 calls, including at least one of each type, during the month. Any deviation from this requirement shall be requested and justified to the RO in order to determine if a waiver is warranted.

- New CSRs - Contractors are encouraged to heavily monitor CSR trainees that have just completed classroom instruction before they begin to handle calls independently. Scores for these trainees will be excluded from CSAMS reporting on QCM performance for a period up to 30 days following the end of formal

classroom training. The calculation will be done automatically when the CSRs are entered into the QCM database with the appropriate indicator of trainee.

C – Type of Monitoring

Monitor the calls in one or more of the following ways:

1. LIVE remote;

2. LIVE side by side (shadow); or

3. Taped.

D - Giving Feedback to CSRs

Complete the scorecard in its entirety and give written feedback to the CSR within 2 working days for calls monitored LIVE or 7 working days for taped calls (Timeframe for giving feedback begins on the day the call occurred). Coach and assist the CSR to improve in areas detected during monitoring.

E – Calibration

Participate in all national and regional QCM calibration sessions organized by CMS. (Calibration is a process to help maintain fairness, objectivity and consistency in scoring calls by staff within one or more call centers or throughout CMS.) National sessions are held on the first Wednesday of February, May, August and November at 1:30 e.s.t. Conduct regular calibration sessions within the call center or between multiple centers. Contractors with more than one reviewer shall conduct monthly calibration sessions within the call center.

F - Retention of Taped Calls

Contractors that tape calls for QCM purposes shall be required to maintain such tapes for an ongoing 90-day period during the year. All tapes shall be clearly identified by date and filed in a manner that will allow for easy selection of tapes for review. Contractors may reuse tapes after the 90-day period. Contractors shall dispose of tapes that are no longer used in a manner that would prohibit someone from obtaining any personally identifiable information on the tapes.

G - Remote Access

The contractor shall provide remote access to *their incoming provider inquiries toll free lines.* CMS personnel *monitoring personnel shall have the capability to monitor provider calls by:*

- *Specific workstation (CSR)*
- *Next call from the network or next call from the CSR queue*
- *Specific business line*

This will allow CMS personnel to hear calls as they are occurring. The CMS will take reasonable measures to ensure the security of this access, (e.g., passwords will be controlled by one person, no one outside of CMS service will have access to the passwords).

20.1.**10** - *Call Center User Group (CCUG)*

(Rev. 9, Issued: 05-06-05, Effective: 02-01-05, Implementation: 06-06-05)

Call centers shall participate in the monthly CCUG calls. The CCUG sessions provide a forum for CMS to discuss new and ongoing projects related to telephone customer service, for contractors to surface issues for CMS resolution, and call centers to share best practices in telephone customer service delivery. The CCUG is held the third Wednesday of each month at 2:00 p.m. Eastern Time. At a minimum, the call center manager or a designated representative shall participate. Call centers may submit topics for consideration in agenda planning to the CCUG mailbox at ccug@cms.hhs.gov.

20.1.**11** - *Performance Improvements*

(Rev. 9, Issued: 05-06-05, Effective: 02-01-05, Implementation: 06-06-05)

As needed, the contractor shall develop a corrective action plan to resolve deficient performance by staff in the call center, and maintain results on file for CMS review.

20.2 - *Guidelines for Handling Written Inquiries*

(Rev. 9, Issued: 05-06-05, Effective: 02-01-05, Implementation: 06-06-05)

1. The contractor shall stamp *the cover page of* all written inquiries *and the top page of all attachments* with the date of receipt in the corporate mailroom and control them until it sends final answers. *Contractors shall not be required to keep the incoming envelope. However, if it is a contractor's normal operating procedure to keep envelopes with the incoming correspondence, the envelope, incoming letter and any attachments shall be date-stamped in the corporate mailroom.* In addition, the contractor shall:

    - Answer inquiries timely;
    - Not send handwritten responses;
    - Include a contact's name and telephone number in the response;
    - Keep responses in a format from which reproduction is possible;
    - Include the CMS alpha representation on all responses, except for email responses;

- *Not use "Dear Provider" in the salutation of the outgoing response. Instead they shall use the name on the incoming letter or the name in the contractor's system.*

- Forward all appeal requests to the appeals unit for handling.

The majority of contractors currently retain all written inquiries on site. Some contractors house files at a remote location during the year due to cost and space constraints. Those contractors housing written inquiries off site shall notify CMS within 6 weeks of the final BPR date of the exact address/location of their off site written inquiries. This information shall be sent electronically to the servicing RO Provider Branch Chief. This notification is necessary in the event an onsite CPE review is conducted. Contractors are required to allow CMS access to all written inquiries stored off site within 1 day of notification to the contractor so that cases can be retrieved timely. All written inquiries, whether maintained on site or off-site, shall be clearly identified and filed in a manner that will allow for easy selection for the CPE review. Identification data shall be kept that will allow electronic production of a sequential listing of the universe of written inquiries.

20.2.1 - Contractor Guidelines for High Quality Written Responses to Inquiries

(Rev. 9, Issued: 05-06-05, Effective: 02-01-05, Implementation: 06-06-05)

Contractors shall maintain a correspondence quality control program (containing written policies and procedures) that is designed to improve the quality of written responses. In addition, contractors shall perform a continuous quality review of outgoing letters including computer notices. This review consists of the following elements:

1. Accuracy - Content is correct with regard to Medicare policy and contractor data. Overall, the information broadened the inquirer's understanding of the issues that prompted the inquiry.

NOTE: Effective FY 2003, all contractors shall involve clinicians as needed in developing responses to coverage/coding inquiries from providers and use clinicians in scoring the accuracy of responses to coverage/coding inquiries in their quality appraisal program

2. Completeness - The response addresses the inquirer's concerns and states an appropriate action to be taken.

3. Clarity - Letters have good grammatical construction, sentences are of varying length, and paragraphs generally contain no more than five sentences. Use CMS-provided model language and guidelines, where appropriate. Contractors shall process all written inquiries using a 12-point font and a font style of Universal or Times New Roman, or another similar style for ease of reading.

4. Timeliness - Substantive action shall be taken and a final response shall be sent to all provider correspondence within *45 business* days from receipt of the inquiry. In instances where a final response cannot be sent within 45 *business* days (e.g., inquiry shall be referred to a specialized unit for response), the contractor shall send an interim response acknowledging receipt of the inquiry and the reason for any delay. When possible, inform the provider about how long it will be until a final response will be sent.

   Contractors using Interactive Correspondence Online Reporting (ICOR) to document inquiries received from providers and others shall record the correspondence in the electronic environment in a timely manner.

   If the contractor is responsible for handling both Part A and Part B claims, inquiries requiring response from both of these areas share the same time frame for response (i.e., the 45 *business* day period starts on the same day for both responses). Therefore, the contractor ensures that the inquiry is provided to both responding units as quickly as possible. The response to these inquiries may be combined, or separate, depending on which procedure is most efficient for the contractor's conditions. If a contractor responds separately, each response shall refer to the fact that the other area of inquiry will be responded to separately.

   Every contractor shall have the flexibility to respond to provider written inquiries by phone within 45 *business* days. For tracking purposes, the contractor shall develop a report of contact for each telephone response that includes the following information:

   - Provider's name and address;
   - Telephone number;
   - Provider number;
   - Date of contact;
   - Internal inquiry control number;
   - Subject;
   - Summary of discussion;
   - Status;
   - Action required (if any); and
   - The name of the customer service representative who handled the inquiry.

Upon request, the contractor shall send the provider a copy of the report of contact that results from the phone response. The report of contact shall be retained in the same manner and time frame as the current process for written responses. The contractor shall use its discretion when identifying which written inquiries (i.e., provider correspondence that represents simple questions) can be responded to by phone. Use the correspondence that includes the provider's telephone number or use a provider's telephone number from internal records if more appropriate for telephone responses. If the contractor cannot reach the provider by phone, it shall not leave a message for the provider to return the call. It shall develop a written response within 45 *business* days from the incoming inquiry.

5. Tone - Tone is the touch that brings communication to a personal level and removes the appearance that a machine-produced response was used. Appraise all responses, including computer-generated letters and form letters, for tone to make them user-friendly and comprehensible by the reader.

6. E-mail Inquiries – In some cases, an e-mail inquiry received can be responded to by e-mail. Since e-mail represents official correspondence with the public, it is paramount that contractors use sound e-mail practices and proper etiquette when communicating electronically. Contractors shall ensure that e-mail responses utilize the same guidelines that pertain to written inquiries (i.e., timeliness, accuracy, clarity, tone, comprehension). Exception: Responses that are personal in nature (contain financial information, HICN, etc.) cannot be sent by e-mail.

7. Check-off Letters - Check-off letters are appropriate for routine inquiries like claims status or eligibility. Check-off letters shall not be used to address more complex inquiries.

20.3 - *Walk-In Inquiries*

(Rev. 9, Issued: 05-06-05, Effective: 02-01-05, Implementation: 06-06-05)

Contractors shall not actively publicize the walk-in function. However, they shall give individuals making personal visits the same high level of service they would give through phone contact. The interviewer shall have the same records available as a telephone service representative to answer any questions regarding general program policy or specific claims-related issues.

If a provider inquires about a denied or reduced claim, the contractor gives the provider the opportunity to understand the decision made and an explanation of any additional information that may be submitted if an appeal is sought.

The contractor makes the same careful recording of the facts as for a telephone response. The contractor shall maintain a log or record of walk-in inquiries. The log, at a minimum shall include the following:

- Name of inquirer
- Time of arrival
- Time service was provided
- Statement indicating whether the inquiry is closed or still pending

Medicare Contractor Beneficiary and Provider Communications Manual

Chapter 4 - Provider Communications

20.1.7 - New Technologies/Electronic Media

(Rev. 9, Issued: 05-06-05, Effective: 02-01-05, Implementation: 06-06-05)

Contractors must use new technologies and electronic media as an efficient, timely and cost-effective means of disseminating Medicare provider information to the audiences they serve.

A - Provider Education Web Site

Maintain a Web site that is dedicated to furnishing providers with timely, accessible, and understandable Medicare program information. To reduce costs, Web sites should fit into existing infrastructure and use existing resource technologies whenever possible.

This Web site must comply with "Contractor Website Standards and Guidelines" posted at http//cms.hhs.gov/about/web/contractors.asp and must be compatible with multiple browsers. Periodically review the "Web site Standards and Guidelines" to determine your continued compliance. During the first three months of each calendar year, send a signed and dated statement to your RO PCOM or PET Coordinator attesting to whether your Web site continues to comply with these guidelines and whether it is compatible with multiple browsers. The person in your organization who has authority over the Web site should sign the attestation statement.

Your Provider Outreach Web site must contain the following:

- All newly created provider bulletins/newsletters;
- A schedule of upcoming events (e.g., seminars, workshops, fairs.);
- Ability to register for seminars and other events via the Web site;
- Search engine functionality;
- Features that permit providers to download and save copies of bulletins, training materials, schedules of upcoming events, and other items;
- A "What's New" or similarly titled section that contains newsworthy and important information that is of an immediate or time sensitive nature to Medicare providers;
- E-mail based support/help/customer service;

- A listing of FAQs/areas of concern updated quarterly as evidenced through your inquiry analysis program;
- Information for providers on how to submit claims electronically;
- *A "Site Map" for your provider/supplier Web site that shows in simple text headings the major components of your provider/supplier Web site and allows users direct access to these components through selecting and clicking on the titles. This feature must be accessible from the home page of the Web site using the words "Site Map" and must be operational by April 30, 2005; and*
- *A tutorial explanation of how to use your provider education Web site that is accessible from the home page of the provider education Web site. The tutorial must describe how to navigate through the site, how to find information, and explain features of your Web site. The tutorial information can be on a "help" page as long as the" help" feature is accessible from the home page of the provider education Web site. The tutorial feature must be operational by April 30, 2005.*

Develop and implement a feedback mechanism for users of your Medicare Web site. Users must be able to easily reach the feedback instrument from the homepage of your provider education Web site. This mechanism should ask users of your site for their appraisals of the helpfulness and ease of use of the site and the information contained on it, as well as their thoughts and suggestions for improvement or additions to the site. This feedback mechanism must be operational by July 1, 2004.

Within your feedback mechanism provide information about how providers/suppliers can offer reaction to CMS about your performance in their dealings with you. Provide the post office mailing address of your CMS Regional Office PCOM Coordinator as the referral point for these reactions. This information must be on your web site by April 30, 2005.

Your Provider Outreach Web site must link to:

- The CMS Web site at http://cms.hhs.gov/;
- The MLN at http://cms.hhs.gov/medlearn;
- The site for downloading CMS publications at http://cms.hhs.gov/publications/;
- The site for downloading CMS manuals and transmittals at http://cms.hhs.gov/manuals/transmittals/;
- CMS' Quarterly Provider Update (QPU) Web site page at http://www.cms.hhs.gov/providerupdate/main.asp; (Provide an explanation of the QPU on your Medicare provider Web site.) This link is to be on your Web site and operational by April 5, 2004;
- The site that contains descriptions for Remittance Advice reason codes and remark codes at www.wpc-edi.com/servicesreview.asp; (Provide a general explanation of the reason and remark codes on your Medicare

provider Web site.) This link is to be on your Web site and operational by April 5, 2004;

- CMS' HIPAA Web site at http://www.cms.hhs.gov/hipaa/hipaa2; (Provide a general description of the information to be found on this CMS HIPAA site on your Medicare provider Web site) This link is to be on your Web site and operational by April 5, 2004;
- CMS' central provider page at http://www.cms.hhs.gov/providers; This link is to be on your Web site and operational by April 5, 2004;
- CMS' Medicare supplier information site at http://www.cms.hhs/gov/suppliers; This link is to be on your Web site and operational by April 5, 2004; and
- Other CMS Medicare contractors, partners, QIOs, and other sites that may be useful to providers.

1 - Directed Web Site/Bulletin Article

FIs often receive instructions from CMS to print a provider education article or other information in their provider bulletin or newsletter and also place it on their Web site. Unless specifically directed otherwise, locate the article or information from CMS on the "What's New" or similarly titled section of your provider education Web site. Unless specifically directed otherwise, the article or information should be put on the your Web site as soon as possible after receipt, and should remain on your Web site for 2 months, or until the bulletin or newsletter in which it is appearing is put on your Web site, whichever is later.

2 - Use of Current Procedural Terminology

Web sites must adhere to requirements stated in Publication 100-04, Claims Processing Manual, Chapter 23, Subsection 20.7 regarding the use of current procedural terminology (CPT) codes and descriptions. During the first 3 months of each calendar year, determine whether your Web site complies with requirements stated in this Chapter and Subsection of the Claims Processing Manual. Send a signed and dated statement attesting to whether your Web site complies the requirements to your RO PSP or PET Coordinator during the first 3 months of each calendar year. The person in the FI's organization who has authority over the Web site should sign the attestation statement.

3 – Web Site Promotion and Presentations

Actively promote, market and explain your Medicare provider communications Web site. Present information concerning how to find, navigate and fully use your Medicare provider education Web site. This information should be part of, or made available at, all your provider education and training workshops and seminars, training sessions with individual providers, and all other provider education events you have or participate in.

B - Electronic Mailing List/Listserv

1 - General

Maintain at least one electronic mailing list, or listserv, to notify registrants via e-mail of important, time-sensitive Medicare program information, upcoming provider

communications events, and other announcements necessitating immediate attention. At a minimum, use your electronic mailing lists to notify registrants of the availability of bulletins/newsletters or other important information on your Web site. Providers must be able to join your electronic mailing lists via your provider education Web site. Subscribers to your electronic mailing lists must also be able to initiate de-listing themselves via the Web site. Post notices on your Web site and in bulletins/newsletters that encourage subscription to the electronic mailing lists. Your electronic mailing lists must be capable of accommodating all of your providers. It is recommended that your electronic mailing list(s) be constructed for only one-way communication, i.e., from you to subscribers.

2 – Targeted Listservs

Develop and maintain multiple electronic mailing lists that allow you to direct messages and information to segments of the provider population you serve. Use these targeted electronic mailing lists to send messages and information regarding Medicare program, policies, or procedures that are of relevance or interest to specific provider audiences.

You may use the following list to determine applicable provider audiences appropriate to you, and if feasible, develop and use these as targeted provider listserv categories. This list does not preclude contractors from developing or using additional, categorically different or more finite groupings.

Provider Listserv Categories:

Ambulatory Surgical Center, Ambulance, Clinical Diagnostic Laboratory, Community Mental Health Center, Comprehensive Outpatient Rehabilitation Facility, DMEPOS, Federally Qualified Health Center, Hospital, Hospice, Home Health Agencies, Independent Diagnostic Testing Facility, Non-Physician Practitioner, Organ Procurement, Outpatient Physical Therapy Facility, Physician, Renal Dialysis Facility, Rural Health Clinic, Religious Non-Medical Health Care Institution, Skilled Nursing Facility.

3 – Promotion and Membership

Actively market and promote to your provider/supplier community the benefits of being a member of your listserv(s). Use all your regular provider/supplier communications tools and channels (bulletins, workshops, education events, advisory group meetings, written materials, remittance advice messages (if possible), etc.) for this endeavor. The total of unique, individual active members of your listserv(s) must be at 60% or higher of your active provider count by September 30, 2005. For the purpose of calculating this percentage, no one individual member of your listserv(s) can be counted more than once, and active providers are all your individual providers who have had billing activity during the previous 12 months.

NOTE: It is a goal of CMS that your listserv(s) population continually increases. CMS will periodically adjust the percentage requirement stated above in order to accomplish this goal.

4 – Protection and Recordkeeping

You are required to protect your electronic mailing list(s) addresses from unauthorized access or inappropriate usage. Your electronic mailing lists, or any portions or information contained therein, must not be shared, sold or in any way transferred to any other organization or entity. In special or unique circumstances where such a transference or sharing of listserv information to another organization or entity is deemed to be in the best interests of CMS or the Medicare program, the FI must first obtain express written permission of its CMS regional office PCOM or PSP Coordinator.

You must maintain records of your electronic mailing list usage. These records should include when the electronic mailing list(s) were used, text of the messages sent, the number of subscribers transmitted to per usage, and the author of the message. Records must be kept for one year from the date of usage.

30.1.7 - New Technologies/Electronic Media

(Rev. 9, Issued: 05-06-05, Effective: 02-01-05, Implementation: 06-06-05)

Contractors must use new technologies and electronic media as an efficient, timely, and cost-effective means of disseminating Medicare provider/supplier information to the audiences they serve.

A - Provider Education Web Site

Maintain a Web site that is dedicated to furnishing providers with timely, accessible, and understandable Medicare program information. To reduce costs, Web sites should fit into existing infrastructure and use existing resource technologies whenever possible.

This Web site must comply with "Contractor Website Standards and Guidelines" posted at http//cms.hhs.gov/about/web/contractors.asp and must be compatible with multiple browsers. Periodically review the "Web site Standards and Guidelines" to determine your continued compliance. During the first three months of each calendar year, send a signed and dated statement to your RO PCOM or PET Coordinator attesting to whether your Web site continues to comply with these guidelines and whether it is compatible with multiple browsers. The person in your organization who has authority over the Web site should sign the attestation statement.

Your Provider Outreach Web site must contain the following:

- All newly created provider bulletins/newsletters;
- A schedule of upcoming events (e.g., seminars, workshops, fairs.);
- Ability to register for seminars and other events via the Web site;
- Search engine functionality;
- Features that permit providers to download and save copies of bulletins, training materials, schedules of upcoming events, and other items;
- A "What's New" or similarly titled section that contains newsworthy and important information that is of an immediate or time sensitive nature to Medicare providers;
- E-mail based support/help/customer service;
- A listing of FAQs/areas of concern updated quarterly as evidenced through your inquiry analysis program;
- Information for providers on how to submit claims electronically;
- *A "Site Map" for your provider/supplier web site that shows in simple text headings the major components of your provider/supplier web site and allows users direct access to these components through selecting and clicking on the titles. This feature must be accessible from the home page of the web site using the words "Site Map" and must be operational by April 30, 2005; and*

- *A tutorial explanation of how to use your provider education web site that is accessible from the home page of the provider education web site. The tutorial must describe how to navigate through the site, how to find information, and explain features of your web site. The tutorial information can be on a "help" page as long as the" help" feature is accessible from the home page of the provider education web site. The tutorial feature must be operational by April 30, 2005.*

Develop and implement a feedback mechanism for users of your Medicare Web site. Users must be able to easily reach the feedback instrument from the homepage of your provider education Web site. This mechanism should ask users of your site for their appraisals of the helpfulness and ease of use of the site and the information contained on it, as well as their thoughts and suggestions for improvement or additions to the site. This feedback mechanism must be operational by July 1, 2004.

Within your feedback mechanism provide information about how providers/suppliers can offer reaction to CMS about your performance in their dealings with you. Provide the post office mailing address of your CMS Regional Office PCOM Coordinator as the referral point for these reactions. This information must be on your Web site by April 30, 2005.

Your Provider Outreach Web site must link to:

- The CMS Web site at http://cms.hhs.gov/;
- The MLN at http://cms.hhs.gov/medlearn;
- The site for downloading CMS publications at http://cms.hhs.gov/publications/;
- The site for downloading CMS manuals and transmittals at http://cms.hhs.gov/manuals/transmittals/;
- CMS' Quarterly Provider Update (QPU) Web site page at http://www.cms.hhs.gov/providerupdate/main.asp; (Provide an explanation of the QPU on your Medicare provider Web site.) This link is to be on your Web site and operational by April 5, 2004;
- The site that contains descriptions for Remittance Advice reason codes and remark codes at www.wpc-edi.com/servicesreview.asp; (Provide a general explanation of the reason and remark codes on your Medicare provider Web site.) This link is to be on your Web site and operational by April 5, 2004;
- CMS' HIPAA Web site at http://www.cms.hhs.gov/hipaa/hipaa2; (Provide a general description of the information to be found on this CMS HIPAA site on your Medicare provider Web site) This link is to be on your Web site and operational by April 5, 2004;
- CMS' central provider page at http://www.cms.hhs.gov/providers; This link is to be on your Web site and operational by April 5, 2004;

- CMS' Medicare supplier information site at http://www.cms.hhs/gov/suppliers; This link is to be on your Web site and operational by April 5, 2004; and
- Other CMS Medicare contractors, partners, QIOs, and other sites that may be useful to providers.

1 - Directed Web Site/Bulletin Article

FIs often receive instructions from CMS to print a provider education article or other information in their provider bulletin or newsletter and also place it on their Web site. Unless specifically directed otherwise, locate the article or information from CMS on the "What's New" or similarly titled section of your provider education Web site. Unless specifically directed otherwise, the article or information should be put on the your Web site as soon as possible after receipt, and should remain on your Web site for 2 months, or until the bulletin or newsletter in which it is appearing is put on your Web site, whichever is later.

2 - Use of Current Procedural Terminology

Web sites must adhere to requirements stated in Publication 100-04, Claims Processing Manual, Chapter 23, Subsection 20.7 regarding the use of current procedural terminology (CPT) codes and descriptions. During the first 3 months of each calendar year, determine whether your Web site complies with requirements stated in this Chapter and Subsection of the Claims Processing Manual. Send a signed and dated statement attesting to whether your Web site complies the requirements to your RO PSP or PET Coordinator during the first 3 months of each calendar year. The person in the FI's organization who has authority over the Web site should sign the attestation statement.

3 – Web Site Promotion and Presentations

Actively promote, market and explain your Medicare provider communications Web site. Present information concerning how to find, navigate and fully use your Medicare provider education Web site. This information should be part of, or made available at, all your provider education and training workshops and seminars, training sessions with individual providers, and all other provider education events you have or participate in.

B - Electronic Mailing List/Listserv

1 - General

Maintain at least one electronic mailing list, or listserv, to notify registrants via e-mail of important, time-sensitive Medicare program information, upcoming provider communications events, and other announcements necessitating immediate attention. At a minimum, use your electronic mailing lists to notify registrants of the availability of bulletins/newsletters or other important information on your Web site. Providers must be able to join your electronic mailing lists via your provider education Web site. Subscribers to your electronic mailing lists must also be able to initiate de-listing themselves via the Web site. Post notices on your Web site and in bulletins/newsletters that encourage subscription to the electronic mailing lists. Your electronic mailing lists must be capable of accommodating all of your providers. It is recommended that your

electronic mailing list(s) be constructed for only one-way communication, i.e., from you to subscribers.

2 – Targeted Listservs

Develop and maintain multiple electronic mailing lists that allow you to direct messages and information to segments of the provider population you serve. Use these targeted electronic mailing lists to send messages and information regarding Medicare program, policies, or procedures that are of relevance or interest to specific provider audiences.

You may use the following list to determine applicable provider audiences appropriate to you, and if feasible, develop and use these as targeted provider listserv categories. This list does not preclude contractors from developing or using additional, categorically different or more finite groupings.

Provider Listserv Categories:

Ambulatory Surgical Center, Ambulance, Clinical Diagnostic Laboratory, Community Mental Health Center, Comprehensive Outpatient Rehabilitation Facility, DMEPOS, Federally Qualified Health Center, Hospital, Hospice, Home Health Agencies, Independent Diagnostic Testing Facility, Non-Physician Practitioner, Organ Procurement, Outpatient Physical Therapy Facility, Physician, Renal Dialysis Facility, Rural Health Clinic, Religious Non-Medical Health Care Institution, Skilled Nursing Facility.

3 – Promotion and Membership

Actively market and promote to your provider/supplier community the benefits of being a member of your listserv(s). Use all your regular provider/supplier communications tools and channels (bulletins, workshops, education events, advisory group meetings, written materials, remittance advice messages (if possible), etc.) for this endeavor. The total of unique, individual active members of your listserv(s) must be at 25 % or higher of your active provider count by September 30, 2005. For the purpose of calculating this percentage, no one individual member of your listserv(s) can be counted more than once, and active providers are all your individual providers who have had billing activity during the previous 12 months.

NOTE: It is a goal of CMS that your listserv(s) population continually increases. CMS will periodically adjust the percentage requirement stated above in order to accomplish this goal.

4 – Protection and Recordkeeping

You are required to protect your electronic mailing list(s) addresses from unauthorized access or inappropriate usage. Your electronic mailing lists, or any portions or information contained therein, must not be shared, sold or in any way transferred to any other organization or entity. In special or unique circumstances where such a transference or sharing of listserv information to another organization or entity is deemed to be in the best interests of CMS or the Medicare program, the carrier must first obtain express written permission of its CMS regional office PCOM or PSP Coordinator.

You must maintain records of your electronic mailing list usage. These records should include when the electronic mailing list(s) were used, text of the messages sent, the number of subscribers transmitted to per usage, and the author of the message. Records must be kept for one year from the date of usage.